

Fighting COVID-19 in the United States with Federalism and Other Constitutional and Statutory Authority

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The COVID-19 pandemic challenges a workable American federalism. The Tenth Amendment to the U.S. Constitution reserves plenary responsibilities to states for promoting health and well-being; but states and their local governments suffer from a significant lack of resources and interjurisdictional competition during major emergencies. In this article, I argue that a president has significant constitutional and statutory authority for pandemic preparedness and, by law, is responsible for leading a coordinated national response necessary to a pandemic. The article outlines the constitutional and statutory authorities available to President Trump and assesses how he used those powers to address the pandemic. It is argued that early, decisive national coordinative systems for containing and mitigating the virus; testing, tracing, contacting, and isolation protocols; data collection standardization; procurement and distribution of supplies; and planning vaccine eligibility and distribution could have reduced the state and local government disadvantages early in the pandemic, saving lives and boosting the economy.

A recent *Publius* article mentions COVID-19 as the “federalism event of the century” ([Goelzhauser and Konisky 2020](#)). In assessing the poor performance of U.S. governmental institutions in combating COVID-19, some scholars place blame on the nature of American federalism, with its division of powers and reservation of significant authority to state governments resulting in fragmentation of authority, policy-making, and implementation. In this article, I challenge this interpretation of the reasons for the poor performance of American governing institutions in responding to COVID-19, arguing instead that U.S. federal officials not only possessed adequate power to address COVID-19 in the crucial periods of preparation and initial response, but also that it was their responsibility to do so. Failures are attributable to President Donald Trump’s refusal to accept his legal responsibility to lead a coordinated and collaborative national response based on statutory laws that guide health emergencies and catastrophic emergency response.

It is also argued that the President's failure to accept responsibility and exercise existing authority quickly and fully, decisively and competently, increased the problems of state/local capacity and interjurisdictional competition, which led to an excessive loss of lives (Achenbach and Meckler 2020; Hsiang et al. 2020) and increased economic hardship as state and local governments exercised their powers to protect the public.

Public health, not economic recovery, is the focus here because disease containment must occur before strong economic recovery is possible. Issues unanticipated at the Founding of the U.S. Constitution have expanded constitutionally justified national powers during catastrophic events when state/local governments confront unexpected issues that overwhelm their administrative, technical, and financial capacities, and sometimes their political will. COVID-19 respects no boundaries and its demise benefits the entire nation. The "intergovernmental paradox of emergency management" is applicable to a pandemic: state and local governments are at center stage in terms of responsibilities during an emergency, but may be unlikely to perceive of a threat fully, be prepared for it, or possess adequate resources to confront it. The national government must be concerned with jurisdictions nationwide and any obstacles to prevention, mitigation, preparedness, response, and recovery (Cigler 2007). This paradox suggests the significance of the "who's in charge?" questions related to pandemic response.

The article proceeds by first outlining scholarly arguments that attempt to explain the largely failed COVID-19 response and identifying key omissions in many analyses. In analyzing the design of both the U.S. public health and emergency management systems, I highlight the unambiguous coordinative responsibility required of the federal government in a major health catastrophe, focusing on the major statutory powers and authorities of the president. This is followed by a discussion of the performance of the Trump Administration's leadership role and coordinative responsibilities set forth by law. A concluding section summarizes why federalism was not the cause of the poor U.S. COVID-19 response.

Federal Government Authority to Respond to Catastrophes

Writing about the U.S. response to the pandemic, McDonald, Goodman, and Hatch (2020) cite numerous articles that accurately depict the bottom-up design of the U.S. disaster response system, which begins with local first responders and acknowledges assistance from state and national governments, as needed. Overlooked, however, is that emergency management adjusts during catastrophic events and that emergency statutory powers become available for a pandemic response that the authors depict as "uncertain due to the novelty of the situation"

and conclude that “limitations of federal government authority hinder the ability to lead a response.” Kettl (2020) acknowledges the lack of a comprehensive federal response to COVID-19 and discusses the need for national leadership, but does not examine existing federal powers to assess whether a president possesses what is necessary to lead a national response, suggesting instead that it was President’s Trump’s “choice” and not his “responsibility” by law to lead and coordinate the pandemic response. Like so many other scholars who have assessed federalism’s role in the COVID-19 response, Kettl concentrates on the patchwork of state and local responses throughout the pandemic. In another article, Kettl (2021) focuses on scientific uncertainty, arguing that it made uniting around solutions such as mask wearing uncertain and suggested that the “bigger questions” of when national actions or state leadership are needed remain unanswered.

Kincaid and Leckrone (2020) argue that the federal government responded “vigorously” *initially* but that “constitutional dualism” resulted in a “lack of authority” to impose key policies such as stay-at-home orders and mask mandates. They note a pattern of “erratic, insufficient, and sometimes destructive” federal support and unproductive use of the media and maintain that the novelty of the virus made the “best” national policy response “not immediately evident” and conclude that the “federal government lacks constitutional authority to command a national response.” They do not attribute response drawbacks to structural flaws in federalism and point to party partisanship and preferences by the president, governors, and other executives that frustrated an effective response. Like Kettl, they refer to “choices” and not responsibilities defined by law. Like Kettl, they do not consider preparation or the effects of the gamut of early national actions on the state/local response. These distinctions are important because a focus on choices/preferences by President Trump can overshadow a focus on legal responsibilities and, thus, accountability.

In contrast to the public administration scholars, some legal (Berman 2020; Knauer 2021) and presidential (Rudalevige and Yu 2020) scholars consider statutory powers when assessing the U.S. national response to COVID-19 and conclude that the national government had extensive powers to combat the approaching coronavirus and that it had a legal coordinative responsibility to do so. Preparedness and the earliest stages of the response are suggested to be highly consequential. Scholars at the Max Planck Institute, in addition, examine U.S. pandemic response action within international law (von Bogdandy and Villarreal 2020), adding to an understanding of U.S. national coordinative responsibilities.

Clearly, federal authority is not plenary and there are limits to what federal officials can do. There is no federal power to close or reopen schools or businesses or require individual mask-wearing outside of federal property, or issue lockdown or stay-at-home orders. However, state actions can be encouraged through persuasion, funding, and other incentives. A president can offer clear consistent

“guidelines” to states for nonpharmaceutical mitigation (stay-at-home, social distancing); testing, contacting, and isolation protocol; data collection and analysis protocols; clear and consistent criteria for reopening schools/businesses; and vaccination priorities and distribution guidance. Federal officials cannot “command” states to discharge their public health responsibilities, but they *do* possess a significant degree of statutory grants of power for responding to a major health emergency. In fact, key legislation explicitly states that the president has the *responsibility* to take the lead in a catastrophic emergency and to *coordinate* a national response. The choice involved is whether to accept the responsibility.

Limitations of Existing Arguments regarding Federalism’s Role in a Pandemic Response

Existing assessments of federalism’s role in the pandemic can be faulted for failure to incorporate several key concerns:

1. Presidents and their administrations have both constitutional *and* expansive statutory powers during major emergencies; but most scholars focus solely on constitutional powers.
2. The U.S. public health and emergency management systems are flexible, adapting differently to catastrophic events than to “bottom-up” routine emergencies.
3. With regard to saving lives and reducing the duration of economic disruption, the key focus should be on preparedness/planning and early, decisive response. Containment strategies such as international travel bans and non-pharmaceutical interventions are most important early when it is possible to keep the virus out of a nation and when drugs and vaccines are not yet available. Similarly, testing, contact tracing, and isolation protocols are important early to target interventions by state/local governments and to “buy time.” Standardized coordination of data collection and analysis also is a key to targeted intervention and tracking community spread of a virus. The availability of supplies for health care workers and patient treatment, testing, and vaccinations all call for quick action that avoids excessive costs and detrimental competition. While vaccine development is the best hope for winning the war on the virus, success depends on the ability to inoculate, which not only requires adequate testing supplies and personnel, but also efforts to thwart any vaccination hesitancy of the public. As such, the best approach for examining federalism’s role in a pandemic is to assess actions taken or not taken and with what outcomes in the early days and weeks of the disease. The negative effects of federalism such as inadequate capacity, interjurisdictional competition, an uncoordinated patchwork of policies, etc. within national-state and state-local relations are, in large part, the result of national government initial action or inaction.

4. Understanding federalism's ability to fight a pandemic should rely on insights from the literature on federalism and intergovernmental relations, but also that of public law, public health, and emergency management, especially during catastrophes, along with the texts of major laws and existing plans. Using these sources, this article finds support for its conclusion that President Trump and his administration had the legal authority—and responsibility—to lead a comprehensive, coordinated national response to COVID-19 in ways that would help state/local jurisdictions early enough to lessen the widely noted problems with state/local governments' ability to handle their responsibilities. The questions of who's in charge of what during a catastrophic emergency are addressed in existing laws.

The U.S. Public Health and Emergency Management Systems

The U.S. public health and emergency management systems reject a strict dual federalism model of “either-or” that would divide responsibility and power into discrete categories. Instead, a cooperative federalism model that uses a flexible application of the Tenth Amendment and designs systems that envision national government leading cooperative relations within itself and with the states is in place. Shared power is at the heart of federalism, so leadership matters—including the need to coordinate all actors and government levels while working with the private and nonprofit sectors. Questions regarding who's in charge, who's responsible for various activities, and who will be held accountable become central to vertical and horizontal implementation policy success. The systems are centered on the executive branches of government levels—those most responsible for coordinating and implementing plans within their branches, among and between jurisdictions, and with the other sectors (Holahan, Weil, and Wiener 2003; [Mariner et al. 2020](#)).

The U.S. public health system is highly decentralized and fragmented at every level, making coordination challenging. States and 3,000 local public health departments are most responsible during a health emergency and different structural models for state implementation are allowed, enabling state choices and ability to transfer innovative ideas. Autonomy and experimentation are promoted. Moreover, while there is competition and cooperation among and between jurisdictions, they can work together to negotiate with their national counterparts. There are clearly *not* separate spheres of public health federalism, nor is any level subservient; instead, the public health system is adaptive on all levels (Gluck and Huberfeld 2018; [Gostin and Wiley 2020](#); Gordon, Huberfeld, and Jones 2020).

The U.S. public health system was largely “hollowed out” before COVID-19 arrived and even during the pandemic ([Weber et al. 2020](#)). Since 2008, local health departments have lost nearly 25 percent of their workforce, with budgets flat on

average. Small departments operate with 11 percent fewer resources and large departments with 30 percent fewer resources, not considering inflation (Himmelstein and Woolhandler 2016; National Association of County and City Health Officials 2020).

State and local health departments focus more on chronic diseases (e.g., heart disease and diabetes) than infectious diseases. Local systems vary by state in structure, funding, capacity, and effectiveness. Fully trained staff, adequate equipment, stockpiled supplies, and strong funding are not the norm. It is the national government that possesses an enormous amount of resources to deal with health emergencies; however, even the Centers for Disease Control and Prevention (CDC) has endured significant budget cuts in recent years, hampering the ability to investigate diseases, gather and analyze data, and develop adequate testing procedures (Farberman et al. 2020).

For the management of domestic emergencies, the U.S. established a single comprehensive approach in 2003: *A National Response Framework* (NRF). State and local jurisdictions are given initial responsibility during a disaster event, but when their resources are overwhelmed, or when the national government's interests are involved, that level assists and also works with other sectors. Global pandemic planning falls within this national preparedness and response strategy, which integrates the national government's domestic prevention, preparedness, response, and recovery plans into one "all hazards" plan (Homeland Security Act of 2002, Pub. L. 107–296, 116 Stat. 2135, codified at 6 U.S.C. § 101 ET seq.). *The NRF places ultimate responsibility on the President for the federal response to catastrophic incidents to ensure that the necessary resources are applied quickly and efficiently.*

Specific threats such as a pandemic are addressed by the NRF's *Annex on Biological Incidents*, revised in 2017 (U.S. Department of Homeland Security 2017). National government roles and responsibilities include national declarations; operational coordination; public information and warning; Personal Protective Equipment (PPE); a Defense Production Act (DPA); resource adjudication, screening, medical and nonpharmaceutical interventions; health and medical services; modeling; waste management; relocation, alternative housing and re-occupancy; and patient transportation.

The NRF includes a comprehensive management system for responding to domestic incidents regardless of the cause, size, location, or complexity, called the National Incident Management System (NIMS). Prepared by the Secretary of the Department of Homeland Security (DHS), it provides a list of Emergency Support Functions (ESFs), which categorize the capabilities and services of all sectors potentially needed in a disaster. These comprehensive ESFs are central to NIMS and the NRF in guiding the Federal Emergency Management Agency (FEMA) in taking a coordinative lead in emergency response. For COVID-19, ESF-8 Public Health and Medical Services is of key importance in knowing response needs and

Health and Human Services (HHS) is the lead federal agency for dealing with public health; medical surge support and patient movement; behavioral health services; mass fatality management; and veterinary, medical, and public health services.

The Trump Administration released the National Biodefense Strategy and National Biodefense Strategy Implementation Plan to address the possibility of pandemic flu in 2018. It covers naturally occurring, accidental, or intentional biological agents ([U.S. Department of Homeland Security 2017](#)). The Implementation Plan to combat a pandemic explicitly acknowledges both that the national government is the key actor and that international cooperation is essential in dealing with infectious disease threats ([U.S. Department of Homeland Security 2017](#)).

The wording used in documents to explain the nation's "all-hazards" approach to "incident management" does not fully depict the challenge of a global pandemic, which is a rolling disaster of unknown duration, not a confined incident. More important, however, is that substantial pandemic-focused guidance exists for a president (e.g., [Blue Ribbon Study Panel on Biodefense 2015](#)). In fact, the language used in the *National Strategy for Pandemic Influenza Implementation Plan* compares a severe pandemic to a war or widespread economic crisis, not as a hurricane, earthquake, or terrorist act ([Homeland Security Council 2006](#), 2).

The national government is not only responsible for coordinating a comprehensive and timely national response to a catastrophic event; it also has primary responsibility for what the emergency management community labels as "critical functions." These include the support of containment efforts overseas and limiting the arrival of a pandemic to the US; guidance on protective measures that should be taken; modifications to laws and regulations to facilitate a national pandemic response; modifications to monetary policy to mitigate the economic impact of a pandemic; and procurement and distribution.

[Glock \(2020\)](#) points to more than a dozen existing pandemic plans consisting of thousands of pages written by various agencies. Plan revisions and updates utilize lessons learned from the Zika virus, Ebola outbreaks, H1N1 pandemic, Avian flu and other events, all available on the CDC website ([U.S. Department of Health and Human Services 2017](#)).

Existing laws and plans as the pandemic reached the United States included the importance of foreign containment to prepare for the disease within the United States; the need to develop nonpharmaceutical mitigation options, such as protocols for physical distancing and school/business closings, in case containment is not successful; the need for diagnostic tests, contact tracing, and protocols for state/local action; effective treatment, and a vaccine, which would require streamlined approval processes and distribution priorities; a workable supply chain for medical supplies and flexible approval of waivers; and honest, accurate and timely information to the public; attention to the disruptions of daily life for extended periods that would be inevitable during a severe health emergency;

adequate surge capacity and more hospital beds, and ventilators; anticipation of shortages of PPE; preparation for overwhelmed mortuary services; and clear guidelines for managing communications with state, local, and tribal authorities, institutions, the public, and global partners. It is important that the *Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019* (P. L. 116-22), became law and provided funding and planning authority shortly before the first case of COVID-19 reached the United States on January 21, 2020.

Despite problems, U.S. emergency and pandemic plans *designate and assume* that strong, decisive national leadership within constitutional powers and limitations will occur. Once health agencies signal the spread of a dangerous virus, plans are supposed to be implemented. Coordinative responsibility for the assault on COVID-19—among national government agencies, national-state relations, and internationally—places the national government at center stage with the president, specifically and unambiguously, designated as the lead.

Within the existing strategy and management frameworks. President Trump and his Administration had extraordinary emergency declaration powers, several other powerful legal tools useful to a coordinated, comprehensive national response, and all of the resources of the national government. The following subsections highlight key laws with attention to issues of the timing of actions so important to understanding the national response to COVID-19.

Emergency Declarations

The Department of Health and Human Services (HHS) is the lead agency for pandemic preparedness, plans, and coordination with bioengineering research and hospitals and helps with testing and vaccines, as well as ethical issues pertaining to treatment and supplies. Health agencies play advisory roles in public health emergencies and also provide valuable data. For COVID-19, the HHS Secretary declared a public health emergency on January 31, 2020 using the *Public Health Services Act* (PHSA), which unleashed aid to the states and suspended and modified many health rules and regulations, States also waived regulations. Hospitals and providers, thus, gained flexibility from complex regulatory requirements. The *Public Health Services Act of 1944* (P.L. 78-410, 58 Stat. 682) was amended by the *CARES Act* (March 2020, P.L. 116-136) to add ventilators to the list of items in the National Stockpile, explained below. Because it was a health emergency declaration, HHS was put in charge of the national response and the HHS Secretary originally chaired the official Coronavirus Task Force that was created. On January 31, 2020, the FDA also declared a public health emergency to allow quick approval of new diagnostic tests and state lab oversight.

On March 13, 2020, President Trump used *The National Emergencies Act (NEA) of 1976* (P.L. 94-412, 90 Stat. 1255) to declare a national emergency regarding

COVID-19. This allowed for emergency powers to suspend rules and regulations from dozens of statutory provisions related to public health, military, trade, agriculture, transportation, communications, criminal justice, and other policies. It also allowed the HHS secretary to waive or modify legal restrictions, such as limits on telemedicine and requirements on healthcare providers to expand their capacity, as well as easing regulations to allow more labs.

Federal Emergency Management Agency

Not all states have laws allowing public health emergencies; instead they can declare general emergencies that can include health. For COVID-19 all states declared emergencies and President Trump made emergency declarations for all states, tribes, territories, and the District of Columbia. This brought FEMA into the pandemic response and enabled states to receive disaster relief funding and logistical support. FEMA's role stems from the *Robert Stafford Disaster Relief and Emergency Assistance Act* (42 U.S.C. §5191 et seq.) authorizing a President to declare a national emergency and to provide aid to state and local governments, typically for natural hazard-related disasters such as flooding and hurricanes, not public health crises.

FEMA is not a large agency so hires contractors, for example, to help with sheltering and meals with charities and faith-based organizations. For the pandemic, many contracts were extended for supplies and their distribution. FEMA uses NIMS under the NRF to provide guidance to states and local governments, which are required to have emergency plans, and to the private sector and non-governmental organizations (NGOs).

Stockpiling and Supply Chains

A deadly pandemic requires massive amounts of products, including their production and distribution with attention to costs, quality, and equity. PPE, such as surgical gloves, N95 masks, hospital beds, ventilators, etc. are needed as are testing supplies such as reagents and swabs. Therapeutics and vaccinations require systems for production, but also syringes, needles, glass vials, rubber stoppers, and swabs, as well as allocation decisions. Vaccinations require equitable distribution to multiple types of sites (hospitals, pharmacies, mass clinics) and ways to bolster community engagement.

A President's access to supplies has multiple routes, beginning with a forty billion dollar reservoir in the Stafford Act to draw upon for medical equipment and supplies. The *Defense Production Act* (DPA) (50 U.S.C. § 4511 et seq.) offers substantial power to order private companies to produce and expedite production of goods and materials including coordination among manufacturers. Its other authorities are issuing loans to expand capacity; control of product distribution; and the ability to compel prioritization of products ordered by government. HHS

also can require private businesses to prioritize government contracts to produce PPE and equipment.

The United States also has a number of strategic stockpiles. For COVID-19, the Strategic National Stockpile (SNS) has medical supplies and equipment such as ventilators and beds to supplement state/local resources. The SNS had an \$8B inventory for the pandemic, with its composition determined by CDC, FDA, and the National Institutes of Health (NIH). The Strategic Petroleum Reserve stores oil barrels in sites in Texas and Louisiana. FEMA has eight distribution centers for food, water, and generators. Other national stockpiles did not come into play during the pandemic.

Planning and Drills

The Obama Administration had a dedicated pandemic team at the National Security Council (NSC) that created the Global Health Security and Biodefense Directorate to have a permanent team of experts available to plan for and implement a response to emergencies such as a global pandemic (Berman 2020). It was disbanded in 2018 by the Trump Administration, leaving political appointees with significant influence on health issues. The Obama Administration gave a sixty-nine-page Pandemic Playbook to the Trump Administration (Executive Office of the President of the United States n.d.) and other handbooks to HHS and CDC. The detailed decision-making process for responding to a pandemic in the Playbook would have empowered the NSC's pandemic office to lead a coordinated national response. It states: "the American public will look to the U.S. Government for action when multi-state or other significant public health events occur." After disbanding the pandemic office, the Trump White House never had a lead unit to deal with COVID-19.

In October 2019, HHS held a pandemic drill, *Crimson Contagion*, with some states and national agencies and FEMA had a pandemic drill. CDC health experts were at the World Health Organization (WHO) when it sent a worldwide alert in early January 2020 about China's poorly understood but spreading disease. U.S. public health experts in government and universities, self-named as the "Red Dawn" group, wrote frequently about a likely pandemic and urged preparation. CDC issued travel alerts on January 6–8, 2020. The President's Daily Briefings included pandemic updates, the HHS secretary warned in a memo and phone call about a possible pandemic, and the President's trade adviser wrote memos about the coronavirus in late January (Lipton et al. 2020).

Task Forces

An official Coronavirus Task Force was formed on January 29, 2020 chaired by the HHS Secretary, but soon replaced by Vice President Pence. Members included health and intelligence experts and cabinet secretaries. The group initially held daily

press briefings to inform the public about the worsening health threat but President Trump eventually conducted the press briefings and was widely criticized for conveying misinformation. Other task forces were created during the initial months of the pandemic but with never met or were quickly and quietly disbanded.

Trump Administration Decision-Making in Response to Covid-19

Decisions, actions, and inactions of President Trump and his Administration regarding the pandemic led to a flawed response. Four broad problem areas are reviewed here: (i) A lack of foresight and planning; (ii) slow action in the exercise of powers clearly possessed, in some cases; (iii) in other cases, not using authority clearly possessed; and (iv) failing to forge collaborations when having direct power to order action or responsibility to support actions at other levels.

Lack of Foresight and Planning

President Trump stated repeatedly that “No one could have predicted something like this” when referring to COVID-19 ([Schwartz 2020](#); [Lipton et al. 2020](#)), despite multiple plans and exercises predicting a major pandemic, which provided detailed guidance, especially the Obama Playbook. Major laws explain lead responsibility and procedures governing health catastrophes, designating the president and national government (FEMA and HHS) to be in charge.

While \$18.5 billion was invested in gambling successfully on vaccine creation in record time, just \$8.2 billion was spent on therapeutics, including coordination of large trials and shared data. Drugs save lives, especially when vaccines are not available at the beginning of a disease event as a virus multiplies quickly when many people are susceptible ([Zimmer 2021](#)). There was not centralized leadership for coordinating eligibility guidelines or distribution of vaccines in the planning stages or after (Hennigan, Park, and Ducharme 2021). Similarly, there were no national strategies for data collection, supply chain, equity issues related to vulnerable populations (minorities, the homeless, prisoners, nursing homes). And, there were not national protocols for testing or consistent guidance to states regarding nonpharmaceutical interventions.

The *Washington Post*’s interviews with twenty-two senior officials early in the pandemic found stockpiling PPE and other medical supplies such as testing kits was discussed early by the official Task Force, but border control was prioritized instead (Parker, Aboutaleb, and Dewey 2020).

Slowness and/or Ineffective Use of Authority and Powers

The CDC made immediate, significant errors in refusing WHO tests even temporarily, developing its own defective tests, and turning late to the private

sector without field teams ready to detect cases or trace contacts. None of these problems were the fault of the President, however, he didn't make an effort to have them corrected. State and university laboratory officials complained about the crucial delays and were approved for developing and analyzing tests. In the meantime, the President made false statements and unachievable promises about testing that continued throughout his presidency. Promises made through early March 2020 included a Google website, tests for everyone, drive-through testing, and a surveillance system for five American cities to measure the disease spread and to locate hot spots. None materialized.

[Atkinson et al. \(2020\)](#) offer a comprehensive understanding of the supply chain problems early during the pandemic, which were far beyond slow action and were characterized by the lack of cohesive procurement policies that deviated from all best practices beginning with the President's assertion that his Administration was "not a shipping clerk" and that governors are responsible for securing supplies.

The growing threat of the disease in late 2019 and early 2020 was either not recognized or denied by the President, contributing to a slow response. Missteps and mixed messages fraught with denials, distractions, misinformation, disinformation and empty promises caused early confusion ([Paz 2020](#)). The President focused in January–February and into March on the economy more than on health issues, Vice President Pence, as Task Force chair, had productive phone calls with governors, but a comprehensive national strategy for liaison with state/local officials was never developed. The President's few encounters with governors were often contentious and included conflicting statements regarding responsibility. Initially he claimed "total authority" over the states and warned governors of political consequences if they refused his authority, but quickly withdrew and told governors that they were responsible for the life and death decision-making needed to battle the coronavirus. That so-called "choice" was a refusal to accept legal responsibilities that created challenges of lost responsibility/accountability across the governance system. This made it more difficult for state/local officials to secure voluntary compliance for their actions such as ordering lockdowns, stay-at-home orders, and mask wearing and complicated the ability to secure supplies, test, vaccinate, and accomplish other tasks.

The National Strategic Stockpile (NSS) was slow to move needed PPE and equipment where needed. Much in stock was outdated or quickly depleted and to restock FEMA bid against states, which increased costs. Jared Kushner, adviser to the President and his son-in-law, mistakenly claimed that the NSS is for the national government, not the states and the Administration supported his misunderstanding by changing the wording on the Stockpile website to match his claim. When the President, against medical advice, promoted an anti-malarial drug as a COVID-19 cure, millions of pills were purchased and subsequently stored in the Stockpile after FDA warned against their use other than in hospitals and

clinical settings. A Kushner-headed task force to help states with supplies was highly criticized for its secrecy, favoritism, and use of inexperienced volunteers (Brittain, Stanley-Becker, and Miroff 2020).

The President was slow to designate FEMA to assume the lead role for emergency response, waiting until March 18, 2020. By April, the agency was pressed to prepare for the hurricane season beginning in June so lead roles were shifted. FEMA's early operations were heroic at times (e.g., building temporary hospitals with the U.S. Army Corps of Engineers) but, at other times, work was slow and ineffective. Governors and medical personnel complained throughout the Trump presidency and especially during the crucial first months about the lack of essential supplies and competition among themselves that they could not resolve. Rising costs of PPE due to worldwide shortages and price gouging, bidding wars, and poor distribution were met with inaction or slowness. Supply gaps required closure and improved allocation among states because medical supplies are largely manufactured abroad. The Trump Administration shifted priorities from FEMA's operational coordination over PPE and hospital equipment logistics to a longer-term recovery strategy prematurely by focusing on reopening the economy during spring 2020 when the virus was not well-contained.

Not Using Existing Authority

Under authority of the Constitution's Commerce Clause the President issued limited travel restrictions on China, Italy, and Spain that went into effect in early February 2020—with many exemptions. Travel restrictions from many European nations were included six weeks later. Hundreds of thousands of travelers had already entered the United States before the restrictions and after the exemptions. A real-time table top exercise modeled after the Crimson Contagion drill led the Task Force to the realization that a containment strategy attempting to keep the virus out of the United States and to isolate those infected was not working and had to evolve to a focus on a mitigation strategy to stop the spread of COVID-19 until a vaccine became available. Physical distancing and more aggressive measures that would disrupt the economy were recommended to President Trump in late February but he offered inflated rhetoric and promises in public statements instead and didn't recommend guidelines to state/local officials until mid-March but almost immediately spoke against his Administration's guidelines and did so until his term ended.

President Trump was hesitant to use the full powers of the DPA because of a concern about nationalizing private businesses, which the law doesn't do. Instead, it orders, expedites, and pays industry for essential goods, even protecting against liability. He was not hesitant to use the DPA to help relieve oil/gas industry suffering from low demand and sinking revenues so purchased oil to fill the

Strategic Petroleum Reserve. The DPA was used to order the opening of meat processing plants after COVID-19 infected thousands of workers in hundreds of plants, frightening others from going to work, which closed plants, reduced operations, and resulted in meat and poultry shortages. There was less concern for worker safety as the Department of Labor was not used to protect workers.

The DPA was used for ventilator production but only after a delay occurred and new medical knowledge about COVID-19 had lessened the need for ventilators. President Trump then sent many abroad, not considering the possibility of future surges of COVID-19. Overall, the DPA was used less initially to help slow the spread of the disease than to boost the economy. By May, it was used to secure swabs and eventually was used extensively for vaccine development.

Coordination Failures or Inefficiencies

A September 2020 release of eighteen taped interviews with President Trump by Bob Woodward for a book, revealed intentional misleading of the public about the seriousness of COVID-19 very early during the pandemic (Bump and Parker 2020; Costa and Rucker 2020). A Cornell University study of COVID-19 misinformation in 38,000 articles in English-language media found President Trump mentioned in 37.9 percent of misinformation statements—more than any other topic. The conclusion was that he was likely the largest driver of COVID-19 misinformation in the world (Evanega et al. 2020). Other early investigations arrived at similar conclusions (HaBerman 2020), finding that Americans had low levels of trust in the President's pandemic statements before the Woodward revelations (Pace and Fingerhut 2020).

Distrust of scientists (Friedman 2020) and medical personnel was unwavering throughout the pandemic by the President, who promoted unproven remedies and pressured state and local governments to reopen their economies quickly, and against medical advice. Armed protestors were encouraged to “liberate” their states from infringement on their personal liberties due to state/local stay-at-home, mask wearing, and lockdowns. Excessive partisanship and favoritism regarding supply chain issues occurred (Mulvihill 2020) and emergency management professionals claimed that the politicization of the disaster response directed by the White House was unprecedented in modern history in rewarding contracts and allocating resources (Allen, McCausland, and Farivar 2020). The Select Subcommittee on the Corona Crisis (2020) documented forty-seven separate incidents within a pattern of political interference in the nation's coronavirus response. Examples include suppression of whistleblower concerns; altering, delaying, and suppressing guidance and scientific reports by federal health agencies such as the CDC and FDA; removal and sidelining of health experts; and authorizing questionable medical treatments after scientists objected. The analysis was based on public reporting with full citations of the articles used provided in the document, published after 207,000 U.S. deaths.

The examples of the President's lack of support for state and local officials is just one part of his lack of coordinative success. His executive branch was fraught with infighting, turf wars, and rivalries among officials and agencies, first documented through mid-March 2020 by Haberman and Weiland. Clear assignment and priorities were not established. When the dedicated pandemic team at the NSC was disbanded in 2018, professional expertise for planning and implementing a response to COVID-19 was diminished in the Administration and political appointees had significant influence on health issues. Disregard of the Obama pandemic Playbook meant that plans for decisive national action, especially in coordinating a response were also diminished.

The Administration's official Task Force didn't include some key health officials and high turnovers and staff vacancies led to less direction, oversight, and mentorship making coordination across the bureaucracy difficult. A number of President Trump's health officials explained clashes with the appointed HHS Secretary over testing and the Administration's significant interference with important CDC reports (Panetta 2021).

Early in his interactions with state officials, the President conveyed puzzling interpretations of his role in the federal system. He once claimed that he had "total authority" (Flynn and Chiu 2020; Savage 2020) then that the states should handle things such as securing PPE on their own on the open market because the national government was not a "shipping clerk" (Forgey 2020) and only a "supplier of last resort." Procurement problems, confusion, and bidding wars were eventually reduced but not eliminated and the greatest setbacks to the states were early when the disease outbreak began.

A president has the power to make binding international agreements and coordinate activities with other nations (von Bogdandy and Villarreal 2020). Global cooperation is needed in the race for treatments and vaccines, which involves negotiation, collaboration, and plans. The United States refused to join the global coordinated effort organized by WHO, despite resolutions of support from the United Nations and G20 and G7 nations. President Trump chose not to support the funding of an initiative launched in April 2020 aimed at developing pharmaceuticals to prevent, diagnose, and treat the disease and to ensure that countries had equal access to products. WHO was accused of colluding with China, had its U.S. funding suspended, and was urged to fire its head—all in the midst of the pandemic and before any investigations.

Conclusions

Ambiguous, fragmented federalism; complex and often competitive intergovernmental relations; and inadequate state/local capacity are a challenge to any governance system. COVID-19 is a stress test of federalism but before concluding

that the system failed, it's necessary to contemplate whether quick, bold, farsighted, and decisive national action, especially at the crucial beginning of the disaster, could have adapted to contain and mitigate the health threat to avoid the severity of problems associated with federalism, leading to better outcomes for people and economies. Catastrophes test leadership. COVID-19 is a rolling catastrophe of yet unknown duration and unsettled detection, treatment, and cure that exceeds state/local capacities. National action impacts state/local disaster response success regardless of the confines of the Tenth Amendment. The national government can build state and local government capacity for executing their powerful police powers and help to decrease interjurisdictional competition.

President Trump had extensive powers and statutory authorities to lead a national effort and undertake the necessary coordinative functions to stop the march of the virus—he had choices to make but it was his “legal responsibility” and not his option to choose to avoid the leadership role for fighting COVID-19. The states were not supposed to be in charge. If President Trump's decisions were made in different ways that were quick and decisive, the virus-response likely would have been more effective. He was not constrained in his ability to act by limits on federal power. Different actions early in preparing for and responding to COVID-19 likely would have overcome many of the inadequate capacity and interjurisdictional competition problems that hampered the work of states and their local governments.

No one person or organization was prepared for COVID-19. Its onslaught exposed faults in nearly all of society's systems—medical; economic; government; safety net; logistics; communications; etc. Each may also spur innovations and solutions. Government's performance is just one part of human failure, but its primary role is to protect life. Preparing for a pandemic and a successful initial response is critical. The toughest decisions and challenges are yet to come as both public health and economic recovery and rebuilding must be balanced.

This article reviewed common expectations of a leader fighting a war against a silent enemy, to use President's Trump's language. These include:

- Early, decisive, and effective action within the bounds of legal authority.
- Consistency in words and actions.
- Use of facts to create credibility and trust.
- Respect for expertise, evidence-based decision-making, and detail.
- Leading by example, which boosts morale and voluntary compliance.
- Acceptance of responsibility and avoidance of unsupported blaming of others.
- Avoidance of excessive partisanship.
- Acceptance of oversight and transparency.
- Collaborative relationships within the national executive branch, with state/local governments, other sectors, and the international community.

President Trump denied the scope, seriousness, and lethality of COVID-19 in his public presentations. He ignored warnings regarding the threat. He knew the facts but was not truthful with the American people. Despite laws placing responsibility on him to undertake leadership of a national response and to coordinate all relevant actors, President Trump chose to let governors and local officials be most responsible for life and death decision-making, testing strategies, procurement of supplies, re-opening of schools and economies without clear guidance, and he had no coherent plan for vaccine distribution or equity concerns. Distrusting segments of the population challenged expert advice and state actions. Governors received reluctant help from a president holding enormous authority and resources in overcoming the inherent fragmentation of the intergovernmental system and the lack of subnational capacity.

The “who’s in charge” question related to a pandemic is answered not simply by looking to the Tenth Amendment or Commerce Clause; instead, the full statutory powers and authority of the national executive branch must be taken into consideration. Federalism is not the issue; instead it’s taking bold, decisive national action. Recent studies support this conclusion. The Lancet Commission recently concluded that the United States could have averted 40 percent of its pandemic deaths had President Trump made different choices. Columbia University’s National Center for Disease Preparedness suggested 130,000–210,000 fewer deaths early in the pandemic if there had been stronger national action ([Redlener et al. 2020](#)).

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